Form 207 Revised 12/20/2004 "This form, when filled in, contains patient information that must be protected in accordance with the Health Insurance Portability & Accountability Act."

Kentucky Health Services Laboratory 100 Sower Blvd., North Loading Dock, P.O. Box 2020 Frankfort, Kentucky 40602-2020 Phone: 502/564-4446 Fax: 502/564-7019 William D. Hacker, M.D., Acting Director

Please complete a separate form for each specimen. Yellow copy may be retained by the submitter.

## Mycobacteriology Smear & Culture

PATIENT INFORMATION:						
Name (Last, First, MI)						tely
Social Security #	Sex	Rac	ce	Age	DOB	- mple
Home Address						- 00 II
City State	Z	ip Code	County			-
Send Report To:						el or
Submitter						' Lab
Street Address (PO BOX)						Please Use "L" Label or Fill in Completely
City State	Z	ip Code				lease L
Requesting Physician (if other than	submitter)					- 🗖
Specimen Information:						
•	Date of Co	ollection				
☐ Clinical Specimen		Re	ferred S	Specime	n	
Sputum	Sputum Source:					
☐ Bronchial Washing						
☐ Gastric fluid		lospital or	Labora	tory refere	ence number	
☐ Urine		(if applicable)				
□ CSF	(				/	
Other, please spec	ify					
Is the patient on anti-tuberculo	sis drugs?	☐ Yes	6	☐ No		
Laboratory Findings:						
Laboratory Number:						